Gynecology Obstetrics

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Request Date: ____________________________

Patient Name:____ DOB_______________________

Contact Phone No. ____

► **PLEASE CHECK ONE OF THE FOLLOWING REQUESTS:**

☐ I authorize the Seasons Women's Care to **RELEASE** my medical records to:

Provider/Facility ____

Address ____

City, State, Zip ____

Phone# / Fax# ____

☐ I authorized the Seasons Women's Care to **OBTAIN** my medical records from:

Provider/Facility ____

Address ____

City, State, Zip ____

Phone# Fax# ____

REASON FOR REQUEST: Transfer of Care______ Relocation______ Other________________________________

TYPE OF RECORDS REQUESTED: Entire Records_____ *Other (specify)_________________________________

I am authorizing release of all my record which may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health. If the person or facility receiving this information is not a healthcare or medical provider covered by privacy regulations, the information stated above could be re-disclosed. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Your provider is allowed to charge you a fee for the requested records. Charges for personal use $1.00 per page, up to 25 pages then $0.25 every page after that. There will be No Charge to send your records to another provider.

Patient Signature or Representative____ Date: ___________________

Provider Signature ____